

Exhibit 73

* Auth (Verified) *

DO NOT SIGN THIS FORM UNTIL A PHYSICIAN HAS EXPLAINED IT TO YOU, YOU HAVE READ IT AND FULLY UNDERSTAND ITS CONTENTS.

Patient: Monique M Russell Date 5/24/2016 Time _____

The following has been explained to me in general terms and I hereby authorize the performance of a **CESAREAN SECTION (PRIMARY OR REPEAT)** and I understand the following. *only in the case of a medically necessary event or emergency.*

PROCEDURE

Delivery of a baby through a cut (incision) in the mother's belly and uterus

PURPOSE

Delivery of your infant through an incision in your abdominal wall

BENEFIT:

Planned delivery date, reduced risk of fetal birth trauma and fetal hypoxia

RISKS (This is not an exhaustive list meaning that there can be other unlisted risks):

- **Maternal:** Urgent hysterectomy, thromboembolic events (blood clots), DIC (disseminated intravascular coagulation), anesthetic complications, major puerperal infection, amniotic fluid embolism, uterine artery pseudoaneurysm, wound infection, hematomas, wound disruption, bladder puncture, urethral and bowel laceration, persistent pain at the incision site, cesarean scar endometriosis, cesarean scar ectopic pregnancy, placental accretia, dense intra-abdominal adhesions, increased hospital stays, lengthy physical recovery, increased risk of readmission, chronic pelvic pain, increased risk of complications in future deliveries, future uterine ruptures, increased risk of future C-sections, death and cardiac arrest
- **Infant:** The infant can experience, among other things, surgical cut or injury to infant's scalp or presenting part, increased risk of infant death, respiratory distress, pulmonary hypertension, excess risk of not breast feeding, and surgical lacerations

POTENTIAL PROCEDURES AND THEIR RISKS: We may have to perform one or more of the following procedures in order to assist you with your delivery process

- **Forceps:** An instrument used to grasp and extract the fetal head to facilitate delivery **Risk for mom:** Discomfort **Risk for baby:** Skull fracture, intracranial hemorrhage, facial nerve palsy, and brain injury.
- **Ventouse (vacuum):** A suction cup that attaches to the head of the baby to assist in delivery of fetus **Risk for mom:** vaginal trauma and tears **Risk for baby:** scalp lacerations, cephalohematomas, subgaleal hematomas, intracranial hemorrhage, facial nerve palsies, hyperbilirubinemia, bruising, and retinal hemorrhage
- **Manual Placenta Removal:** placenta is separated from the uterine wall and removed by hand **Risk:** post partum hemorrhage, retained placental fragments, and pain
- **Cardiotocography:** the monitoring of the fetal heart rate and uterine contractions during labor and delivery **Risk for baby** No risks are associated with external monitoring Fetal scalp infection with internal monitoring
- **Pelvimetry:** measurement of the capacity and diameter of the pelvis **Risk:** discomfort and pain
- **Pitocin administration:** delivery of medication post delivery to increase uterine activity **Risk for mom:** over stimulation of the uterus, uterine rupture Failure to administer could result in increased risk of bleeding and its associated outcomes including loss of uterus and death. Yes _____ No _____
- **Transfusion of blood/blood products:** is a procedure to replace blood loss **Risk:** carries the risk of exposure to HIV, hepatitis and other infectious diseases and allergic reactions

Monique Russell

CESAREAN SECTION (PRIMARY OR REPEAT)
(Page 1 of 3)

DIMENSIONS HEALTHCARE SYSTEM



4-487 (09/13)

PATIENT LABEL

MR 11096170
RUSSELL, MONIQUE MELISSA
308005529
DOB 05/24/16 7 38Y F
MOORE, JAVAKA L/D

* Auth (Verified) *



ALTERNATIVE PROCEDURES, TREATMENTS AND THEIR RISKS: The only alternative to a C-Section is a vaginal delivery.

- **Maternal.** Paralysis or partial paralysis, paraplegia or quadriplegia, brain damage, uterine inversion, uterine rupture, need for an emergency C-section, placenta previa, placenta abruption, anal sphincter injury, bowel injury, bladder injury or injury to other abdominal structures, possible fistula formation (opening between bowel, bladder, ureter, vagina and/or skin), perineal or genital tears and scars, possible formation of clots; possible emboli (clots or other material that may travel to other parts of the body) hysterectomy (removal of uterus, fallopian tubes and/or ovaries) persistent penneal pain, pre-eclampsia, amniotic emboli, sexual dysfunction, anal incontinence, urinary urge incontinence, urinary stress incontinence, DIC (disseminated intravascular coagulation) and pelvic floor prolapse, cardiac arrest, maternal death and fetal death
- **Infant** Can experience oxygen deficit from a prolapsed cord, brachial plexus injury, nuchal cord, scalp infection from fetal scalp monitoring, facial nerve injury, precipitous delivery, subdural hematoma, sub-arachnoid hematoma, cerebral palsy, meconium aspiration, and newborn neurological symptoms and can be stillborn

THE INFORMATION GIVEN ABOVE IS NOT AN EXHAUSTIVE LIST MEANING THAT THERE CAN BE OTHER UNLISTED RISKS WE CANNOT PREDICT WHETHER OR NOT ANY OF THE ABOVE MAY BE NEEDED OR MAY OCCUR

I understand that the physician, medical personnel and other assistants will rely on statements about the patient, the patient's medical history, and other information in determining whether to perform the procedure or the course of treatment for the patient's condition and in recommending the above procedure


I understand the practice of medicine is not an exact science and that NO GUARANTEES OR ASSURANCES HAVE BEEN MADE TO ME concerning the results of this procedure

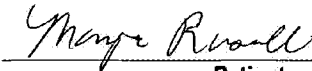
I understand that during the course of the procedure described above it may be necessary or appropriate to perform additional procedures which are unforeseen or not know to be needed at the time this consent is given. I consent to and authorize the persons described herein to make the decisions concerning such procedures. I also consent to and authorize the performance of such additional procedures as they deem necessary or appropriate.

I also consent to diagnostic studies, tests, anesthesia, x-ray examinations and other treatment or courses of treatment relating to the diagnosis or procedures described herein

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE READ OR HAD THIS FORM READ AND/OR EXPLAINED TO ME, THAT I FULLY UNDERSTAND ITS CONTENTS, AND THAT I HAVE BEEN GIVEN AMPLE OPPORTUNITY TO ASK QUESTIONS AND THAT ANY QUESTIONS HAVE BEEN ANSWERED SATISFACTORILY. ALL BLANKS OR STATEMENTS REQUIRING COMPLETION WERE FILLED IN AND ALL STATEMENTS I DO NOT APPROVE OF WERE STRICKEN BEFORE I SIGNED THIS FORM

I voluntarily consent to allow Dr. Waldrop or Moore or any physician designated or selected by him or her and all medical personnel under the direct supervision and control of such physician and all other personnel who may otherwise be involved in performing such procedures to perform the procedures described or otherwise referred to herein. **Unless rescinded, this consent will remain in effect until delivery.**


Witness

Signed 
Patient

CESAREAN SECTION (PRIMARY OR REPEAT)
(Page 2 of 3)

DIMENSIONS HEALTHCARE SYSTEM



4-487 (09/13)

PATIENT LABEL

MR. 11096170
RUSSELL, MONIQUE MELISSA
308005529
DOB 05/24/16 38Y F MOORE, JAVAKA L/D

* Auth (Verified) *

NOTE: BOTH sides of this form MUST be completed to be VALID.

Patient _____ Date _____ Time _____

- 1 I hereby authorize the performance of the following operation(s)/procedure(s) _____
under the direction of Dr (s) _____
- 2 I have been informed that qualified individuals such as physicians' assistants, surgical assistants and licensed physicians may perform significant surgical tasks to include but not limited to opening and closing, harvesting grafts, dissecting tissue, removing tissue, implanting devices, altering tissues under the direction and supervision of the primary physician listed above
- 3 I have been informed that a vendor representative may be present during the procedure to observe my procedure and/or assist with product selection and placement
- 4 I have been advised of the nature of my condition, the nature and purpose of the proposed operative procedure, and the alternative to this procedure, the risks benefits, and side effects attendant to both the proposed procedure and the alternatives, the probability of success of both the proposed procedure and the alternatives, and the prognosis of the proposed procedure if the alternatives are not performed
- 5 I am also aware that the practice of medicine and surgery is not an exact science and that there are risks and complications associated with the operative procedure. The risks associated with the performance of the proposed and any surgical procedure include but are not limited to severe blood loss, infection and in rare instances cardiac arrest
- 6 I have also been informed of potential problems that might occur during recuperation
- 7 I have been informed that circumstances may arise during the course of treatment that would necessitate the performance of operations and procedures which are different from or in addition to those now contemplated
- 8 This procedure may necessitate the use of blood/blood products which when anticipated will require separate specific informed consent and related documentation. However, in the event of an emergency when specific consent is not possible, I agree to the administration of such products as ordered by my physician
- 9 I impose no specific limitations or prohibitions regarding treatment other than those that follow (if none, so state) _____
- 10 I authorize the examination by an authorized individual of any tissue, organ(s) or body part(s) removed during the procedure and the disposal of such tissue, organ(s) or body part(s) in accordance with hospital policies
- 11 I consent to the admittance of appropriate observers and to the taking and publication of any photographs in the course of this procedure for the purpose of advancing medical education. I understand that my identity will remain confidential
- 12 All of my questions have been answered to my satisfaction. I believe that I have adequate knowledge upon which to base an informed consent to the proposed operative treatment(s)

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT, THAT THE EXPLANATIONS THEREIN REFERRED TO WERE MADE, AND THAT ALL BLANKS OR STATEMENT REQUIRING INSERTION OR COMPLETION WERE FILLED IN AND INAPPLICABLE PARAGRAPHS, IF ANY, WERE STRICKEN BEFORE I SIGNED

Witness

Signed

Patient

Complete the following section if consent is not obtained from the patient

Patient is unable to make an informed decision because patient is (Check appropriate box)

- ☐ Minor _____ years of age without decision-making capacity ☐ Lacks decision-making capacity
☐ Other _____

Patient Representative Signature

Relationship to Patient

Witness Signature (1)

Witness signature (2)

Consent obtained (Check one) ☐ In person ☐ By Telephone [Requires two (2) witness signatures]
Two physician signatures are required in an emergency for consent.

M D

M D

PHYSICIAN DECLARATION Prior to the performance of the procedure described above, I have explained to the patient/surrogate decision-maker the nature, purpose, benefits, risks, alternative treatments, possible consequences and possible complications. I confirm the above surgery/procedure is correct as to procedure, side and site

Physician Signature

Date

Time

CONSENT FOR OPERATIONS AND OTHER PROCEDURES

DIMENSIONS HEALTHCARE SYSTEM

2-567 (7/11)



PATIENT ID: MR 11096170
RUSSELL, MONIQUE MELISSA
308^45529
DOB 05/25/16 38Y F OBS
MOORE, JAVAKA

* Auth (Verified) *

NOTE BOTH sides of this form MUST be completed to be VALID.

Patient Russell, Monique Date 5/25/16 Time _____

- 1 I hereby authorize the Anesthesia Care Team or _____ to administer the following type(s) of anesthetics **General/Regional/Local + IV Sedation/Conscious Sedation** and procedures performed in the provision of anesthesia including placing an intravenous (IV) catheter and maintaining an airway
- 2 The risks associated with anesthesia include but are not limited to worsening of a pre-existing medical problem, airway difficulties and drug reactions. Drug reactions can include a rash, nausea, vomiting, muscle aches, headache, wheezing and very rarely, shock. Maintaining an airway may include placement of an oral or nasal airway, laryngeal mask airway or an endotracheal tube. Reactions to artificial airways include laryngospasm which requires immediate corrective treatment. Manipulation of the airway may result in damage to caps, bridges or damaged teeth and very rarely to sound teeth. Some individuals experience a sore lip, throat or hoarseness. Regional anesthesia blocks may cause headache, numbness or tingling, bleeding or swelling and rarely, weakness or paralysis. Occasionally nerve injuries from positioning may occur. IV catheters can cause inflammation, swelling or bleeding.
- 3 I am also aware that the practice of medicine and anesthesia is not an exact science and that there are risks and complications associated with the anesthesia and anesthetic technique. I have been informed that the aspiration of stomach contents into the lungs, drug reactions including malignant hyperthermia and anaphylactic shock, heart failure, airway closure, paralysis and rarely death may be associated with any anesthetic or anesthetic technique.
- 4 I have been informed that circumstances may arise during the course of treatment that would necessitate the performance of anesthetic techniques and administration of anesthesia which are different from or in addition to those now contemplated.
- 5 I impose no specific limitations or prohibitions regarding anesthesia other than those that follow (if none, so state) _____
- 6 All of my questions have been answered to my satisfaction. I believe that I have adequate knowledge upon which to base an informed consent to the proposed administration of anesthetic(s) and anesthetic techniques.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT, THAT THE EXPLANATIONS THEREIN REFERRED TO WERE MADE, AND THAT ALL BLANKS OR STATEMENT REQUIRING INSERTION OR COMPLETION WERE FILLED IN AND INAPPLICABLE PARAGRAPHS, IF ANY, WERE STRICKEN BEFORE I SIGNED.

Alycia Beave Witness X Monique Russell Patient

Complete the following section if consent is not obtained from the patient

Patient is unable to make an informed decision because patient is (Check appropriate box)

- ☐ Minor _____ years of age without decision-making capacity ☐ Lacks decision-making capacity
☐ Other _____

_____ Patient Representative Signature	_____ Relationship to Patient
_____ Witness Signature (1)	_____ Witness signature (2)
Consent obtained (Check one) <input type="checkbox"/> In person <input type="checkbox"/> By Telephone [Requires two (2) witness signatures] Two physician signatures are required in an emergency for consent	
_____ M D	_____ M D

RESUSCITATION STATUS DURING ANY PROCEDURE REQUIRING INFORMED CONSENT This section is to be completed for patients undergoing any procedure requiring informed consent, who also have orders withholding resuscitation.

- ☐ Patient/surrogate decision-maker requests that DNR order be suspended during any procedure
☐ Patient/surrogate decision-maker requests that DNR order be honored during any procedure

Describe the key features of the discussion(s) pertaining to the DNR issues _____

PHYSICIAN DECLARATION Prior to the time of the planned anesthesia above, I have explained to the patient/surrogate decision-maker the nature, purpose, benefits, risks, and possible complications.

Physician Signature [Signature] Date 5 25 16 Time _____

CONSENT FOR ADMINISTRATION OF ANESTHESIA

DIMENSIONS HEALTHCARE SYSTEM

2-567 (7/11)



MR-11096170
RUSSELL, MONIQUE MELISSA
308005529
DOB 05/24/16 MUORE, JAVAKA 38Y F L/D

* Auth (Verified) *

"MR#"MEDRECMRN%" %ENCNO%DOCTYPENAME% 05-24-2016 18 22 01

Consent to Treatment

PHYSICIANS NOT AS EMPLOYEES: I acknowledge that physicians furnishing services, including but not limited to attending physicians, radiologists, surgeons, emergency department physicians, obstetrician/gynecologists, pathologists, anesthesiologists, neonatologists, physicians interpreting diagnostic studies, consultants and assistants to the physicians ARE NOT employees or agents of the hospital. I understand that I will receive a separate bill from each of these private providers of service. Patient/Patient Representative Initials: *[Signature]*

I am seeking either inpatient or outpatient service from Dimensions Healthcare System (DHS). I understand services are available to me without discrimination as prohibited by federal and state law. I hereby consent to care and treatment, including but not limited to diagnostic medical therapeutic testing and treatment as may be deemed necessary or advisable by my physician, his/her associates, partners or designee, consulting physicians, DHS and its employees, based on his/her medical knowledge and my health condition. I understand I have a right to limit or refuse recommended treatments and/or procedures. I understand that no guarantees have been made to me about the outcome of this care. I understand that health related services may be provided by the employees, agents, and independent contractors utilized by DHS, including but not limited to anesthesiology and other interpretive and diagnostic services.

Medical Education and Training: I understand that DHS is approved to train medical students, residents, nurses and allied health students. I also understand students and residents may observe or participate in patient care. I agree to permit such involvement, unless I notify DHS to the contrary in writing with the understanding the students or resident's work will be under the supervision of a qualified instructor or physician on the medical staff of DHS.

For Inpatient Only: Room charges are incurred for the day of admission or any part thereof, but not the date of discharge. I acknowledge that check-out time is 11:00 a.m. Any balances known to be due for services not covered or partially covered by insurance will be payable at the time of discharge, including but not limited to applicable coinsurance or deductibles.

Personal Property and Valuables: I agree that DHS will not be responsible for patient valuables, clothes, personal items, money or other personal property. I also release DHS from any responsibility for loss or damage to any article not claimed from safekeeping by or for the patient at discharge or departure from DHS premises. Patient/Patient Representative Initials: *[Signature]*

Only Applicable for Medicare Beneficiaries: Statement for Payment of Medicare Benefits to Hospital and/or Physicians — I certify that the information given by me for payment under title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Center for Medicare and Medicaid Services (CMS) or Medicare Intermediaries or Carriers any information needed for these services or a related claim. I request that payment of authorized benefits be made on my behalf.

Insurance Billing and Assignment of Benefits: I assign the benefits payable for hospital or physician services to DHS and/or any physician which renders service to me and authorize them to submit the necessary claims to Medicare for payment. I certify the registration statements are true and I, as guarantor, agree to pay all amounts owed for care and treatment to the full extent permitted by law. DHS may submit claims to my third party payor or, if legally permissible, bill me directly for full or partial payment. I understand that DHS may, at its option, delay billing me directly and this does not alleviate my responsibility for payment. I agree to pay all amounts owed by me, or the Insured, Member or Subscriber, for treatment to the full extent permitted by law. I assign any benefits which I or the Insured, Member or Subscriber may have or be entitled to, to DHS towards payment of my hospital bills and physician bills. I understand that my insurance, HMO, or other healthcare benefits are subject to verification by DHS and that I will remain responsible for any unpaid amounts whether or not covered by this assignment to the full extent permitted by law. I understand and agree that I am responsible to pay for any charges for care/treatment/service when I access care/treatment/service outside of my insurance plan network.

Notification of Credit Bureaus Reporting: I understand that DHS may report any outstanding self-pay balances to Credit Bureaus.

Release of Information



I understand that my medical information is confidential and under certain circumstances is protected under federal and state laws and regulations and cannot be released without my written authorization unless otherwise provided for in said regulations. I also understand that I may revoke this consent at anytime except to the extent that action has been taken in reliance on it.

I understand that it may be necessary for DHS, its employees, agents, independent contractors and/or my physician to release and/or disclose all or part of my confidential medical information to third parties for the purposes of providing certain diagnostic treatment and/or testing which may not be available within DHS.

I understand that for the sake of convenience and speed of reference, and to further the timeliness and quality of diagnosis and treatment rendered to me, that any physician, nurse, or business office representative who has been involved with my treatment at a DHS facility may request that the hospital send by facsimile transmission to the physician of record, consulting physician or third party carrier any relevant data from my medical record necessary for continuity of care or reimbursement. It is further understood that with any facsimile transmission there is a possibility that medical records may inadvertently be misdirected. Notwithstanding such risk, I hereby authorize release of any relevant data in my medical record by facsimile transmission to any physician who has participated in my diagnosis or treatment at the hospital or to any third party carrier for reimbursement and hereby release DHS from any liability associated with those risks.

I understand that DHS is the owner of any radiographic images and/or tissue/specimens obtained during the course of my care and treatment. The original radiographic films and/or all of the tissue/specimens will not be released. Copies of radiographic images will be provided, to me or my authorized agent upon written request for a reasonable fee. Tissue blocks will not be available for recut, but will be available for examination under supervision at our facility upon written request.

I understand that the Federal Safe Medical Devices act requires manufacturers of certain medical devices to track the distribution and use of said devices. I understand that DHS must facilitate the tracking of these devices by providing the information to the manufacturer with respect to the patient receiving such a device, which includes releasing my social security number to the manufacturer of the medical device I may receive, in accordance with the federal law and regulations. I understand that my social security number may be used by the manufacturer to help locate me if there is a need to contact me with regard to this medical device. I release DHS from any liability that might result from the release of this information.

UNIVERSAL CONSENT (SIDE 1) DIMENSIONS HEALTHCARE SYSTEM	 MR 11096170 RUSSELL, MONIQUE MELISSA  308005529 DOB 05/25/16 38Y F MOORE, JAVAKA OBS
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0088 (03/16)

* Auth (Verified) *

"MR#"MEDRECMRN%"E ENCNO%DOCTYPENAME% 05-24-2016 18 22 01

Authorization For The Release Of Medical Information To The Maryland Insurance Administration:

Under Maryland law, I have the right to contest a decision by an HMO or health insurer that a proposed or delivered health care service was not medically necessary. The law allows the Health Education and Advocacy Unit (HEAU) of the office of the Attorney General to assist me in filing an internal grievance with the HMO or health insurer and allows me to externally appeal the final decision to the Maryland Insurance Administration (MIA). I may appeal the initial decision directly to the MIA if I can demonstrate a compelling reason not to file an internal grievance with the HMO or health insurer. A health care provider may also file an internal grievance or external appeal on my behalf. By signing this form, I either wish to file an internal grievance or appeal, or I authorize a health care provider to file such a grievance or appeal.

I understand that, as part of the HEAU assisting me with my internal grievance, or MIA handling my external appeal, the HEAU or MIA will contact my HMO or health insurer for an explanation as to its actions in connection with my internal grievance or external appeal, or an internal grievance or external appeal filed on my behalf.

I further understand that MIA may receive advice from medical experts or an Independent Review Organization (IRO) while determining whether to uphold or overturn the HMO or health insurer's decision that a health care service was not medically necessary.

Throughout the grievance or appeal process, the confidentiality of my medical records will be maintained in accordance with Maryland and federal law. I understand that if I have questions about the contents of my medical records to be released, I should contact my health care provider.

I understand that my records may be used to develop general statistical information on grievances and appeals, and any statistical reports will not identify me or contain any identifying information. I do not authorize the release of any information that would identify me to anyone not mentioned above.

In the event I, or a provider on my behalf, file an internal grievance or an external appeal, I authorize the release of my medical records as follows.

1. I authorize the Attorney General and MIA to obtain medical records and insurance information for the purpose of investigating my grievance or appeal.
2. I authorize the Attorney General to release my medical records to MIA so that my appeal or grievance may be investigated, and authorize MIA to release my medical records to the Attorney General so that my appeal or grievance may be investigated.
3. I authorize MIA to release my medical records to the relevant HMO or health insurer, and/or the HMO's or health insurer's legal counsel for the purpose of investigating my grievance or appeal or handling any hearing which may result from such investigation.
4. I authorize MIA to transfer my medical records to the Department of Health and Mental Hygiene if my grievance or appeal involves potential issues of quality of care so that the Department may conduct an investigation into these particular issues.
5. I authorize MIA to release my medical records to medical experts who may assist MIA with my grievance or appeal.

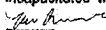
To establish and maintain the safest possible environment in which to deliver care/service/treatment, Dimensions Healthcare System's campus buildings, property, parking lots and operated vehicles are smoke and tobacco-free. Dimensions Healthcare System is dedicated to maintaining a smoke and tobacco-free campus environment.

Dimensions Healthcare Public Health Initiative: If you smoke, please stop smoking.

This form has been explained to me and I understand its contents. I acknowledge the following

- ☒ Receipt of a copy of DHS Notice of Privacy Practices
☒ My communication needs identified by completing the Communication Assessment Form
☐ Receipt of "An Important Message from Medicare" to Medicare beneficiaries
☒ Receipt of DHS brochure "What You Should Know As A Patient"

PLEASE NOTE: All patients 18 and over must sign this consent form themselves, unless they have a legal guardian, personal representative or are incapacitated. If so, the signer must submit written proof of guardianship or representation with this consent form.

 5/24/2016 6 19 34 Signed by JOHNSON, HOLLY on 5/24/2016
Signature of Patient Date Signature of Witness Date

Complete the following section if consent is not obtained from the patient.

Patient is unable to make an informed decision because patient is (Check appropriate box)

- ☐ Minor years of age ☐ Intubated ☐ Unconscious ☐ Emergency Psych Services
☐ Other _____

5/24/2016 6 19 34
Patient Representative Signature Date Relationship to Patient
5/24/2016 6 19 34 PM
Witness signature Date

UNIVERSAL CONSENT (SIDE 2)

DIMENSIONS HEALTHCARE SYSTEM

0088 (02/16)



 MR11096170
RUSSELL, MONIQUE MELISSA
 308005529
DOB 05/25/16 MOORE, JAVAKA 38Y F OBS